

Name _____

QUALITY ASSURANCE MONITORING FORM

Pneumonia

1. Does the individual have any of the following risk factors for pneumonia?
- | | | |
|----|---------------------------------|--------------------|
| a. | Dysphagia | _____ yes _____ no |
| b. | GERD | _____ yes _____ no |
| c. | History of pneumonia | _____ yes _____ no |
| d. | Frequent respiratory infections | _____ yes _____ no |
| e. | Over age 55 | _____ yes _____ no |
| f. | Immobility | _____ yes _____ no |
| g. | Impaired respiratory ability | _____ yes _____ no |
| h. | Immunocomprised | _____ yes _____ no |
2. If yes to any of the above, did the individual receive the pneumonia vaccine (Trivalent 23)? _____ yes _____ no _____ n/a
Comments: _____

3. Has the individual had a respiratory infection in the past year that required antibiotics? _____ yes _____ no
Comments: _____

4. If yes to question 3, were the following performed?
- | | | |
|----|----------------------|------------------------------|
| a. | Physical examination | _____ yes _____ no _____ n/a |
| b. | Chest X-ray | _____ yes _____ no _____ n/a |
| c. | CBC | _____ yes _____ no _____ n/a |
| d. | O ₂ sat | _____ yes _____ no _____ n/a |
- Comments: _____

5. If there has been a clinical indication of pneumonia, were the following completed and documented?
- | | | |
|----|---------------------------------|------------------------------|
| a. | Appropriate antibiotics started | _____ yes _____ no _____ n/a |
| b. | Evaluation of hydration status | _____ yes _____ no _____ n/a |
| c. | Bronchodilators considered | _____ yes _____ no _____ n/a |
| d. | Gram stain of sputum specimen | _____ yes _____ no _____ n/a |
| e. | Blood cultures | _____ yes _____ no _____ n/a |
| f. | Serial radiographs | _____ yes _____ no _____ n/a |
- Comments: _____

6. If individual did not respond to treatment, was the treatment plan changed? _____ yes _____ no _____ n/a
Comments: _____

RECOMMENDATIONS: _____

SIGNATURE _____

DATE _____